



Authorization and Release for Protective Services and Provider Record Checks for Adoption/Foster Care Only

Bureau for Children and Families 350 Capitol Street, B-18 Charleston, WV 25301

Please complete the following and sign below. The form must be legible, and all fields must be filled out COMPLETELY.

Name (Print your full name. Do not use initials): (First Name) (Middle Name) (Last Name)

Birth Date: Social Security Number:

Current Home Address (Give location address, as well as P.O. Box address and County):

If you have not lived at your current address for 5 years, please list the address(es) for your location(s) in the last 5 years:

List maiden name, all aliases, or names known by (Print your full name. Do not use initials):

Agency Name: (who needs to receive verification of the protective service check)

Agency Address:

Agency Contact Information:

Type of Agency:

- Child Placing Foster Care Agency
Adoption Agency
DHHR (Foster Family Home/Certified Kinship Home)

Certification:

I certify that I have not committed any act of child/adult abuse or neglect, as determined by a civil or criminal proceeding or through an investigation by the WV Department of Health and Human Resources or through any like agency of any other state or country, or that I am currently being investigated for such except as stated below:

Authorization:

I authorize the WV Department of Health and Human Resources to conduct a background check on me which includes a search of Child Protective Services records, Adult Protective Services records, Institutional Investigation Unit records and foster care provider records maintained by the Department. I authorize the Department to inform the person or agency named on the front of this form of the results of the background check, including any history I have had with Social Services. **I understand that a positive history of maltreatment in any West Virginia Department of Health and Human Resources protective services record will affect my becoming a kinship, foster or adoptive parent. I understand that any involvement I have had with the WVDHHR as a client or foster care provider will be evaluated and may also affect my becoming a kinship, foster or adoptive parent.** I release the WVDHHR and/or its agents in providing information pursuant to this authorization from any and all liabilities, claims or lawsuits.

(Signature)

(Date)

DHHR Office Use Only

.....

_____ **No record of substantiated maltreatment was found**

_____ **Records indicate that maltreatment occurred by the individual.**

_____ **Records indicate prior or current IIU investigations.**

_____ **Records indicate involvement in a current or past youth services, CPS and/or APS case as an adult.**

_____ **Records indicate a past or current foster care provider record for this individual.**

IF THIS CLIENT HAS ANY QUESTIONS OR NEEDS TO OBTAIN INVESTIGATION RECORDS, THEY MUST CONTACT THE FOLLOWING COUNTY:

COUNTY: _____

INTAKE/CASE #: _____

(DHHR Stamp or Signature of Authorized Individual)

(Date)